

PERFORMANCE AUDIT  
OF THE  
REQUEST FOR PROPOSAL FOR THE OUTSTATE MICHIGAN  
COMPREHENSIVE HEALTH CARE PLAN

DEPARTMENT OF COMMUNITY HEALTH  
AND  
DEPARTMENT OF MANAGEMENT AND BUDGET

May 1999

## EXECUTIVE DIGEST

# REQUEST FOR PROPOSAL FOR THE OUTSTATE MICHIGAN COMPREHENSIVE HEALTH CARE PLAN

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### INTRODUCTION

This report, issued in May 1999, contains the results of our performance audit\* of the Request for Proposal (RFP) for the Outstate Michigan\* Comprehensive Health Care Plan developed by the Department of Community Health (DCH) and the Department of Management and Budget (DMB).

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### AUDIT PURPOSE

This performance audit was conducted in response to a legislative request and as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are typically conducted on a priority basis related to the potential for improving effectiveness\* and efficiency\*.

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### BACKGROUND

The RFP was developed by DCH and the DMB Office of Purchasing. The purpose of this RFP was to solicit proposals from qualified health plans to provide managed care\* programs delivering comprehensive health care services to Medicaid\* recipients in outstate Michigan.

\* See glossary on page 28 for definition.

Proposals submitted pursuant to the RFP were evaluated by a 7-member joint evaluation committee\* (Committee), which used an eight-step process to evaluate proposals received from 23 health plans. Upon completion of its evaluation process, the Committee recommended that the Office of Purchasing award contracts to all 23 health plans, subject to readiness reviews\* to verify that the health plans were adequately prepared to provide health services. Eighteen health plans were initially awarded contracts covering 59 of the 78 outstate counties. Two additional health plans were later determined to be adequately prepared to provide health services and were awarded contracts. As of August 31, 1998, there were 20 health plans covering 65 of the outstate counties.

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**AUDIT OBJECTIVES  
AND CONCLUSIONS**

**Audit Objective:** To assess DCH's and DMB's effectiveness in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally effective in the RFP development, health plan selection, and contract awards recommendation processes. However, we noted a reportable condition\* related to the proposal scores and committee score sheets (Finding 1).

**Audit Objective:** To assess DCH's and DMB's compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally in compliance with State and federal laws and

\* See glossary on page 28 for definition.

regulations in the RFP development, health plan selection, and contract awards recommendation processes.

**Audit Objective:** To assess the adequacy of the financial requirement provisions of the RFP.

**Conclusion:** We concluded that the financial requirement provisions of the RFP were generally adequate.

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**AUDIT SCOPE AND  
METHODOLOGY**

Our audit scope was to assess the development of the request for proposal and the related health plan selection and contract awards recommendation processes for the Outstate Michigan Comprehensive Health Care Plan. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Our objectives were designed primarily to answer the following eight legislative questions:

1. What qualification standards were used to evaluate the health plans?
2. What outcome measurements were included in the RFP?
3. How do the terms of the RFP compare with similar provisions of RFPs issued by other states which have preceded Michigan in managed care initiatives?
4. Did the terms of the RFP comply with requirements of the Health Care Financing Administration, U.S. Department of Health and Human Services?

5. What level of services was required?
6. What involvement was there from the DMB Office of Purchasing?
7. Were the health plans required to submit audited financial statements and, if so, who evaluated them?
8. Do the terms of the RFP allow State and federal agencies to audit contractors' financial and performance practices?

Specific answers to these questions are included in this report as supplemental information.

Our audit methodology included examination of the Outstate Michigan Comprehensive Health Care Plan records and activities for the period December 1, 1997 through August 31, 1998. To accomplish our objectives, we reviewed methods and standards used to evaluate health plans and to measure outcomes and interviewed DCH and DMB staff. We evaluated various features of the RFP for compliance with State and federal laws and regulations, State procurement rules, and contracting laws and regulations. We also evaluated the RFP provisions related to health plans' financial practices and the criteria used in assessing health plans' financial data.

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**AGENCY RESPONSES**

Our audit report includes 1 finding and 2 corresponding recommendations. DCH and DMB agreed with both recommendations.

Mr. James K. Haveman, Jr., Director  
Department of Community Health  
and  
Ms. Janet E. Phipps, Director  
Department of Management and Budget  
Lewis Cass Building  
Lansing, Michigan

Dear Mr. Haveman and Ms. Phipps:

This is our report on the performance audit of the Request for Proposal for the Outstate Michigan Comprehensive Health Care Plan developed by the Department of Community Health and the Department of Management and Budget.

This report contains our executive digest; description of plan; audit objectives, scope, and methodology and agency responses; comments, finding, recommendations, and agency preliminary response; responses to legislative questions and a map showing service regions, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, finding, and recommendations are organized by audit objective. The agency preliminary response was taken from the agencies' responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agencies develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Thomas H. McTavish, C.P.A.  
Auditor General

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## Description of Plan

The request for proposal (RFP) for the Outstate Michigan Comprehensive Health Care Plan was developed by the Department of Community Health (DCH) and the Office of Purchasing, Department of Management and Budget (DMB). The purpose of this RFP was to solicit proposals from qualified health plans seeking contracts with the State to provide managed care programs delivering comprehensive health care services to Medicaid recipients in outstate Michigan.

The Medicaid Program (Title XIX of the federal Social Security Act) is a national health assistance program for families in need of temporary assistance and low-income individuals who are aged, blind, disabled, or members of at-risk groups. In order to implement its managed care initiatives, DCH obtained a Medicaid waiver from the Health Care Financing Administration, U.S. Department of Health and Human Services. The waiver, which was granted on May 30, 1997, authorizes DCH to implement mandatory managed care enrollment and waives sections of the Social Security Act applicable to Medicaid requirements for freedom of choice, comparability of services, and Statewide coverage.

The federal government establishes regulations, guidelines, and policy interpretations that describe the broad framework within which states can tailor their individual programs. Each state operates Medicaid programs under a "state plan," which is developed within this broad framework. Michigan's Medicaid Program is administered by the DCH Medical Services Administration. During fiscal year 1996-97, the Medicaid Program incurred expenditures of \$5.3 billion, of which \$3.4 billion was federally funded and \$1.9 billion was State-funded. The Program provided medical services to approximately 1.1 million recipients Statewide.

Federal authorization granted by the State Medicaid Plan and waiver provisions and Act 352, P.A. 1996, allowed DCH to implement mandatory managed care enrollment for Medicaid recipients residing in counties with managed care options (at least two available health plans). Contracts issued pursuant to the federal waiver and Act 352

result in capitated rates\* based on a competitive bid process as opposed to traditional "fee-for-service"\* provider enrollment.

In fiscal year 1995-96, DCH began to restructure its health care delivery system to become a value purchaser\* of specified health services through mandatory managed care enrollment for the State's Medicaid population. In 1996 and 1997, DCH and DMB developed and implemented a managed care program in the five counties in Southeast Michigan. In July 1997, DMB issued an RFP to solicit bids from qualified health plans to provide a Comprehensive Health Care Program for Outstate Michigan. The RFP was intended to result in contracts for managed care programs delivering comprehensive health care services to approximately 335,000 Medicaid recipients in outstate Michigan at an estimated cost of \$750 million for the contract period July 1, 1998 through December 31, 1999.

The RFP split the 78 outstate counties into 9 regions for purposes of bidding. Bidders for each region were required to have a proposed network of health care providers to serve either the entire region or a significant portion of the region. However, in Region I, bidders were allowed to serve any combination of the three counties in the region (Livingston, Monroe, and St. Clair). On July 1, 1998, DCH implemented its outstate Michigan mandatory managed care program by awarding contracts to 18 of the 23 bidding health plans covering all of 7 regions and parts of the other 2 regions for 59 outstate counties that had at least one qualifying health plan. Two additional health plans were later determined to be adequately prepared to provide health services and were awarded contracts. As of August 31, 1998, there were 20 health plans covering 65 of the outstate counties.

During our audit, health plans were developing provider networks to serve additional counties in accordance with the RFP.

\* See glossary on page 28 for definition.

## Audit Objectives, Scope, and Methodology and Agency Responses

### Audit Objectives

Our performance audit of the Request for Proposal (RFP) for the Outstate Michigan Comprehensive Health Care Plan developed by the Department of Community Health (DCH) and the Department of Management and Budget (DMB) had the following objectives:

1. To assess DCH's and DMB's effectiveness in the RFP development, health plan selection, and contract awards recommendation processes.
2. To assess DCH's and DMB's compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.
3. To assess the adequacy of the financial requirement provisions of the RFP.

### Audit Scope

Our audit scope was to assess the development of the request for proposal and the related health plan selection and contract awards recommendation processes for the Outstate Michigan Comprehensive Health Care Plan. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Our objectives were designed primarily to answer the following eight legislative questions:

1. What qualification standards were used to evaluate the health plans?
2. What outcome measurements were included in the RFP?
3. How do the terms of the RFP compare with similar provisions of RFPs issued by other states which have preceded Michigan in managed care initiatives?

4. Did the terms of the RFP comply with requirements of the Health Care Financing Administration, U.S. Department of Health and Human Services?
5. What level of services was required?
6. What involvement was there from the DMB Office of Purchasing?
7. Were the health plans required to submit audited financial statements and, if so, who evaluated them?
8. Do the terms of the RFP allow State and federal agencies to audit contractors' financial and performance practices?

Specific answers to these questions are included in this report as supplemental information.

#### Audit Methodology

Our audit procedures were conducted during July through August 1998 and included examination of the Outstate Michigan Comprehensive Health Care Plan records and activities for the period December 1, 1997 through August 31, 1998.

To accomplish our first objective, we reviewed methods and standards used to evaluate health plans and to measure outcomes. Also, we compared provisions of the RFP with government contracting standards and RFPs issued by four other states. In addition, we interviewed DCH and DMB staff involved in the development and implementation of the RFP.

To accomplish our second objective, we evaluated various features of the RFP for compliance with State and federal laws and regulations, State procurement rules, and contracting laws and regulations.

To accomplish our third objective, we evaluated the RFP provisions related to health plans' financial practices and the criteria used in assessing health plans' financial data.

### Agency Responses

Our audit report includes 1 finding and 2 corresponding recommendations. DCH and DMB agreed with both recommendations.

The agency preliminary response which follows the recommendations in our report was taken from the agencies' written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and DMB Administrative Guide procedure 1280.02 require DCH and DMB to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

# **COMMENTS, FINDING, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSE**

## **EFFECTIVENESS IN DEVELOPMENT, SELECTION, AND RECOMMENDATION PROCESSES**

### **COMMENT**

**Background:** Proposals submitted pursuant to the request for proposal (RFP) for the Outstate Michigan Comprehensive Health Care Plan were evaluated by a 7-member (6 voting members) joint evaluation committee (Committee), which consisted of staff from the Department of Community Health (DCH), Department of Management and Budget (DMB), Family Independence Agency, and Department of Consumer and Industry Services.

DMB Administrative Guide procedure 0510.07 requires the Office of Purchasing to provide advice on how the Committee should function, to provide Committee members with an evaluation form listing selection criteria for the evaluation process, and to provide the chairperson of the Committee. The procedure also requires the Committee chairperson to summarize Committee meetings, collect proposals and the signed evaluation sheets from the Committee members, prepare a written recommendation for award from the Committee to the State Purchasing Director, and proceed with appropriate steps in the contracting process. The Committee used an eight-step process to evaluate the proposals received from 23 health plans:

1. Proposals were reviewed to determine if they were complete and submitted in accordance with RFP instructions.
2. Proposals were evaluated and assessed to determine if the health plans met standards necessary to become "qualified health plans." Bidders were informed of deficiencies with a time frame for fixing the deficiencies established at the time of readiness review.
3. Proposals were evaluated and scored to determine if they contained attributes applicable to the unique needs of the Medicaid population.

4. Price proposals were evaluated and scored for comparison to the lowest price bid in the region. The scores for the health plans in each region were reduced by the ratio of the lowest price over their price.
5. Scores were compiled based on the first 4 steps.
6. Bidders were notified of deficiencies identified in Steps 2 and 4.
7. Bidders with deficiencies were required to respond in writing to the State with a best and final offer that included changes in the bidders' original proposal necessary to address deficiencies identified by the State in Steps 2 and 4. The bidders were also given an opportunity to make adjustments to their original price proposals.
8. The best and final offers for price were evaluated to ensure that they were below the maximum price for bids. Health plan providers were not required to submit actual best and final offers regarding qualified health plan criteria. Instead, they were instructed to submit plans to correct those deficiencies, which would be validated during readiness review.

In this RFP procurement process, the Office of Purchasing delegated the summarization of the Committee's Step 3 score sheets to DCH staff, who compiled the scores of the Committee onto summary score sheets for the 23 health plans. The reason for this delegation was that DCH would be the only entity using the technical scores for automatic enrollment\* allocations. The Committee members then signed the summary score sheets. In Step 3, the Committee awarded a maximum of 112 points for 14 attributes used to evaluate the health plans' ability to meet the unique needs of the Medicaid population.

Upon completion of its evaluation process, the Committee recommended that the Office of Purchasing award contracts to all 23 health plans, subject to readiness reviews to verify that the health plans were adequately prepared to provide health services. The Office of Purchasing concurred with the Committee recommendations. The State

\* See glossary on page 28 for definition.

Administrative Board approved the contract awards on March 17, 1998, also subject to readiness reviews.

The final proposal scores were used to rank the health plans in each county or region that were awarded contracts. This ranking was important because it was the basis for processing automatic enrollments. The higher ranking health plans received a larger share of these automatic enrollments in accordance with predetermined percentages. This provided incentive for health plan providers to develop quality programs with competitive prices.

**Audit Objective:** To assess DCH's and DMB's effectiveness in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally effective in the RFP development, health plan selection, and contract awards recommendation processes. However, we noted a reportable condition related to the proposal scores and committee score sheets.

## **FINDING**

### **1. Proposal Scores and Committee Score Sheets**

DCH and the Office of Purchasing did not have internal controls to help ensure the accuracy of proposal scores and the Committee's summary score sheets used to determine the ranking order for health plans to receive automatic enrollments of Medicaid recipients. The lack of internal controls resulted in inaccurate proposal scores and summary score sheets because calculation and data entry errors were not detected, which resulted in inappropriate distribution of automatic enrollments.

Accuracy of the proposal scores and the summary score sheets is important because higher ranking health plans receive a much larger share of the automatic enrollments. Errors in ranking could result in more enrollments in lower quality health plans and could be costly to the State if the error negated the effect of the reduction in scores for higher cost health plans.



Our review of proposal scores and the Committee's summary score sheets for 23 bidding health plans disclosed:

- a. There were errors in 15 (17%) of 87 proposal scores reviewed for the nine regions as of August 31, 1998. In 6 instances, DCH inaccurately added the scores from the 14 attributes, making errors of 1 to 4 points when calculating the health plan's total proposal score on the Step 3 score sheet. In 9 instances, the score sheets were accurate, but DCH apparently made errors of 2 to 31 points when copying the total proposal scores to the listing that was used to rank the health plans for making automatic enrollment assignments.

The errors were large enough to affect the ranking of the health plans in 4 counties. Consequently, the automatic enrollments that began September 1, 1998 were not appropriately distributed in these 4 counties. The following table illustrates the effect on the automatic enrollment process:

Health Plan	County	Erroneous Ranking	Correct Ranking	Erroneous Percentage*	Correct Percentage*
A	Lapeer	1	2	50%	30%
B	Lapeer	2	1	30%	50%
C	Huron	1	2	60%	40%
A	Huron	2	1	40%	60%
C	Sanilac	1	2	60%	40%
A	Sanilac	2	1	40%	60%
C	Tuscola	2	3	30%	20%
A	Tuscola	3	2	20%	30%

\* Of total automatic enrollments.

- b. The summary score sheet for one health plan in one region was blank for each of the 14 attributes; however, the health plan received a contract for 3 counties. DCH informed us that it had scored this health plan with a score of

45 and used this score in the contract award process. DCH also informed us that the scores were inadvertently omitted from the summary score sheets that were signed by the Committee.

- c. Four health plans' summary score sheets contained apparent data entry errors. For example, one health plan's summary score sheet indicated 12 points for one of the attributes that was supposed to be scored from 1 to 5 points, and another health plan's summary score sheet indicated 1 point for an attribute that was supposed to be scored either 15 points or 0 points. For three health plans, the summary score sheets indicated a total score of 4 points in a region when the individual attribute scores totaled 40, 41, and 47. Although the Committee did not detect these errors during the scoring process, DCH used the correct amounts in the ranking of health plans for automatic enrollment assignments.

The number of errors indicates that DCH and the Committee did not thoroughly review the proposal scores and summary score sheets for accuracy. The noted errors could have been caught by a routine checking of the scoring process. DCH and the Office of Purchasing need to establish internal controls that would detect and correct such errors.

Accurate documentation is essential to ensure the integrity of the evaluation process in determining if health plans meet established standards. In addition, the Committee's summary score sheets are the only documentation available to support health plans' rankings in the regions they received contracts.

## **RECOMMENDATIONS**

We recommend that DCH and the Office of Purchasing develop internal controls to help ensure the accuracy of proposal scores and the Committee's summary score sheets used to determine the ranking order of health plans to receive automatic enrollments of Medicaid recipients.

We also recommend that DCH correct erroneous proposal scores and related erroneous rankings of health plans identified during this audit.

## **AGENCY PRELIMINARY RESPONSE**

DCH agreed with the first recommendation and informed us that it would work with the Office of Purchasing to develop additional controls to ensure the accuracy of scores and the reporting of these scores on the score sheets. The Office of Purchasing informed us that it has complied with the recommendation and that controls are in place to ensure the accuracy of the Committee's summary score sheets.

DCH also agreed with the second recommendation and informed us that it has already corrected the initial errors identified in our audit. The errors were corrected during the first scheduled revision of the automatic enrollment algorithm. The rankings were corrected in September for implementation in October 1998. Based on the information discovered during the audit and in combination with DCH's own internal process, the error, which had an immaterial effect on a limited number of rural counties, was discovered and the inappropriate distribution of automatic enrollments was limited to a single one-month period.

## **COMPLIANCE WITH LAWS AND REGULATIONS**

### **COMMENT**

**Background:** The RFP process is governed by State laws, procurement rules, and contracting laws and regulations. The federal government establishes regulations, guidelines, and policy interpretations which describe the broad framework within which states can tailor their Medicaid programs.

**Audit Objective:** To assess DCH's and DMB's compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally in compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.

## ADEQUACY OF FINANCIAL REQUIREMENT PROVISIONS

### **COMMENT**

**Background:** Standards used by the Committee to evaluate health plans' qualifications were based on health maintenance organization licensing standards. This included requirements for financial viability, such as minimum net worth, adequate working capital, written financial plan, and insolvency protection.

**Audit Objective:** To assess the adequacy of the financial requirement provisions of the RFP.

**Conclusion:** We concluded that the financial requirement provisions of the RFP were generally adequate.

# SUPPLEMENTAL INFORMATION

## RESPONSES TO LEGISLATIVE QUESTIONS

### **Summary Overview**

The following eight questions were included in the legislative request to audit the request for proposal (RFP) for the Outstate Michigan Comprehensive Health Care Plan (Plan) developed by the Department of Community Health (DCH) and the Department of Management and Budget (DMB). Each question is followed by our response:

**Question 1:** What qualification standards were used to evaluate the health plans?

**Response:** Standards used to evaluate the health plans' qualifications were based on health maintenance organization (HMO) licensing standards:

(1) **Organizational and Administrative Structure**

The bidding health plan has corporate qualifications and experience as a managed care organization and has senior level managers and skilled clinicians for medical management activities.

(2) **Administrative Requirements**

The bidding health plan has policies, procedures, clinical guidelines, medical records, reporting formats, liability coverage, and provider network information specific to delivering Plan services.

(3) **Financial Viability**

The bidding health plan is financially and actuarially sound with adequate working capital and required trust indenture deposits.

(4) **Ability to Meet Levels of Service**

The bidding health plan has a network of participating health care providers and agreements with local health departments.

(5) **Accessibility**

The bidding health plan has adequate locations of primary care physicians and hours of availability.

(6) Management Information System

The bidding health plan has a system capable of collecting, processing, reporting, and maintaining data in accordance with RFP requirements.

(7) Accreditation

The bidding health plan has or will obtain accreditation from an appropriate accrediting organization.

(8) Licensing

While bidding health plans are required to meet qualification standards consistent with HMO licensing standards, the RFP does not require qualified health plans to become a licensed HMO.

(9) Incorporation

The bidding health plan is a Michigan corporation or a limited liability professional association.

(10) Governing Body

The bidding health plan's governing body has at least 33% of its membership consisting of adult enrollees of the bidding health plan and will ensure adoption and implementation of written policies governing the operation of the qualified health plan.

(11) Insolvency Protection

Qualified health plans will be required to meet financial solvency standards to guarantee payment of the plans' obligations to providers and guarantee performance of the plans' obligations under the contract.

In accordance with DMB Administrative Guide procedure 0510.07, these qualifications were evaluated by a joint evaluation committee (Committee). The 7-member (6 voting members) Committee included staff from DCH, DMB, the Family Independence Agency, and the Department of Consumer and Industry Services. An independent contractor and staff from DCH assisted the Committee in evaluating certain standards. DCH completed readiness reviews of each bidding health plan to ensure that it was prepared to meet the conditions of the contract as stipulated in the RFP.

**Question 2:** What outcome measurements were included in the RFP?

**Response:** The RFP included the following six minimum outcomes that successful health plans are expected to achieve during the contract period:

- (1) Immunizations initiated for 100% of infants.
- (2) Age-appropriate immunizations for 90% of all two-year-olds.
- (3) Age-appropriate well child/Early and Periodic Screening, Diagnosis, and Treatment screenings for at least 90% of the children.
- (4) Appropriate blood pressure and cholesterol screenings for at least 75% of adults age 40 and over.
- (5) Maternal support services to at least 60% of pregnant women at risk.
- (6) Mammographies for at least 60% of women age 40 and over.

Additional requirements complementing the six minimum outcomes include: an "encounter data reporting system," which requires the successful health plans to provide DCH with data on the services provided to enrollees; a "Grievance/Complaint Adjudication Coordinator" and management information system capabilities for processing enrollee grievances and complaints; submission of required reports on quality improvement programs; and annual enrollee satisfaction surveys conducted in collaboration with DCH.

**Question 3:** How do the terms of the RFP compare with similar provisions of RFPs issued by other states which have preceded Michigan in managed care initiatives?

**Response:** We obtained managed care RFPs from other states (Indiana, Pennsylvania, Missouri, and Arizona) that recently implemented similar RFPs and compared them with the Michigan RFP. Our comparison included provisions for evaluation standards, performance measures, outcome measurement reporting, level of services, involvement of state purchasing offices, financial and post-audit requirements, and compliance with federal Health Care Financing Administration



(HCFA) requirements. We found that the provisions of the Michigan RFP did not differ significantly from those of the other four states.

**Question 4:** Did the terms of the RFP comply with HCFA requirements?

**Response:** The terms of the RFP complied with HCFA requirements. DCH requested a waiver to mandate enrollment of Medicaid recipients into a managed care program. HCFA reviewed the terms of the RFP and submitted a series of questions that were answered by DCH. The waiver was approved May 30, 1997.

**Question 5:** What level of services was required?

**Response:** The level of services required by the RFP is consistent with that presently offered by the Plan. Services include:

- (1) Specialty provider network care.
- (2) Inpatient and outpatient hospital care.
- (3) Home health services.
- (4) Hospice.
- (5) Rehabilitation services.
- (6) Immunizations.
- (7) Short-term mental health care (up to 20 visits).
- (8) Specialty dental services.
- (9) End-stage renal disease services.
- (10) Ancillary services, such as durable medical equipment, medical equipment and supplies, laboratory, and radiology and nuclear medicine.

(11) Emergency services.

(12) Pharmacy services.

(13) Transplants and implants.

(14) Vision services.

(15) Early and Periodic Screening, Diagnosis, and Treatment Program.

(16) Cystic Fibrosis and Coagulation Disorders Over Age 21 Program (children under age 21 are also covered for these conditions).

The RFP excluded certain primary health care services, such as inpatient and outpatient psychiatric services; nursing home and nursing home services; experimental or investigational drugs, procedures, or equipment; and mental health services in excess of 20 outpatient visits annually.

**Question 6:** What involvement was there from the DMB Office of Purchasing?

**Response:** The Office of Purchasing was involved in the development and implementation of the RFP. The Office of Purchasing issued the RFP and was named as the sole point of contact for all procurement and contractual matters. Also, the Committee was chaired by an Office of Purchasing employee.

**Question 7:** Were the health plans required to submit audited financial statements and, if so, who evaluated them?

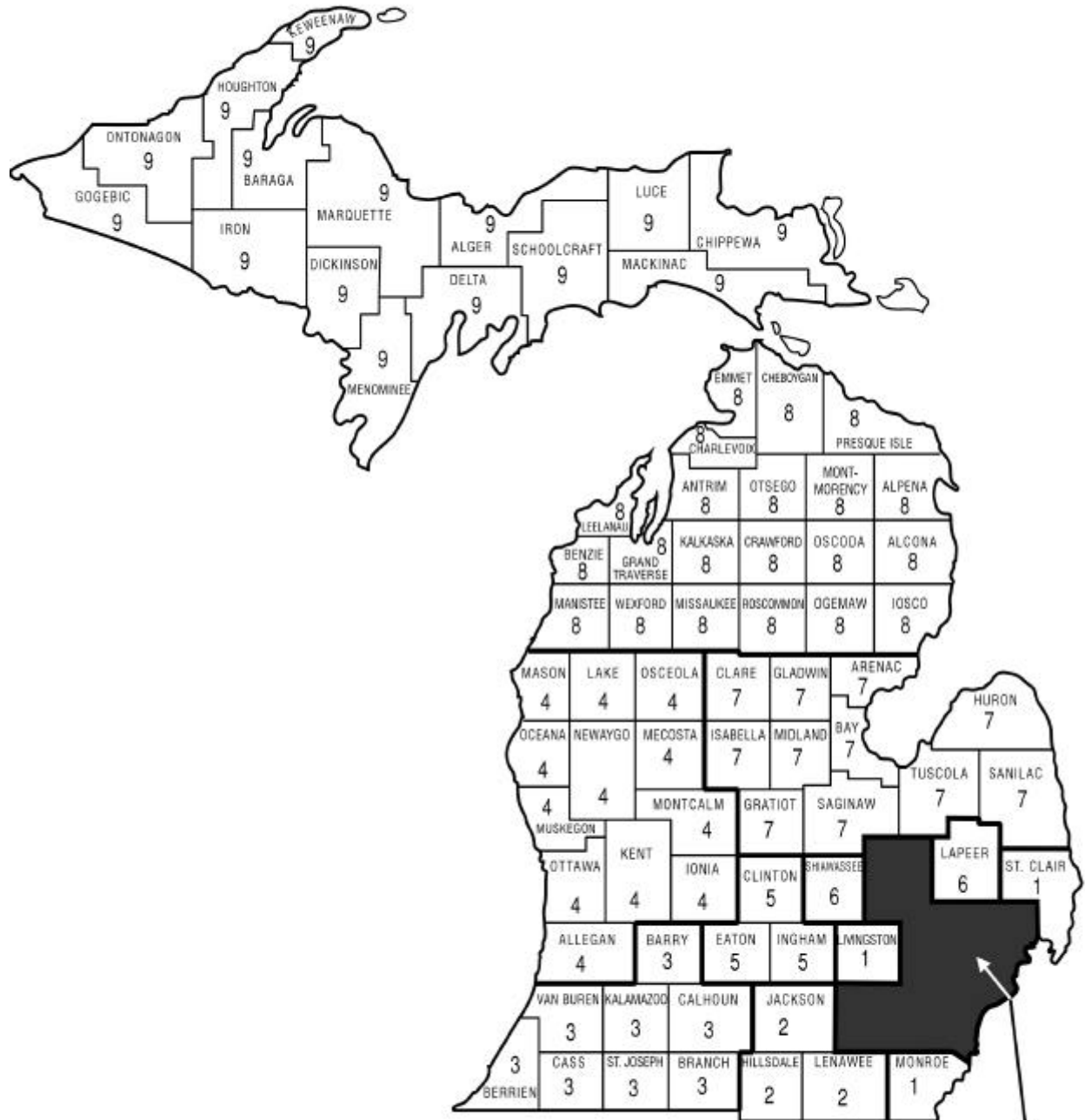
**Response:** Health plans were not required to submit audited financial statements with their bids. However, they were required to be financially and actuarially sound with a minimum net worth of \$100,000, adequate working capital of \$250,000, and required trust indenture deposits. The financial plans were to include the bidding health plan's means of achieving and maintaining a positive cash flow, provisions for retirement of existing or proposed debt, an insolvency protection plan, and provisions for an appropriate amount of working capital.

All financial information was evaluated by the Committee and was verified during the readiness review process. Also, the RFP specifies that successful health plans are required to submit certified annual audits and quarterly financial statements meeting standards of the Michigan Insurance Bureau, Department of Consumer and Industry Services.

**Question 8:** Do the terms of the RFP allow State and federal agencies to audit contractors' financial and performance practices?

**Response:** The RFP specifies that accounting records are to be maintained for a period of six years and are subject to audit by HCFA, the Attorney General, the Auditor General, and other designated State agencies. The RFP also indicates that medical records, policies, procedures, and guidelines are subject to review by DCH and HCFA or their designated agents.

**REQUEST FOR PROPOSAL FOR THE  
OUTSTATE MICHIGAN COMPREHENSIVE HEALTH CARE PLAN  
Service Regions**



Counties in shaded area are not included in this Request for Proposal. These counties were included in the November 1996 Request for Proposal for the Southeast Michigan Comprehensive Health Care Program.

## Glossary of Acronyms and Terms

automatic enrollments	Assigned enrollment with health plan providers for the Medicaid recipients who did not choose their own health plan providers.
capitated rate	A fixed per person monthly rate payable to the contractor by DCH for provision of all covered services defined within the request for proposal.
DCH	Department of Community Health.
DMB	Department of Management and Budget.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
fee-for-service	Health care paid for with a charge for each service provided.
HCFA	Health Care Financing Administration, U.S. Department of Health and Human Services.
HMO	health maintenance organization.
joint evaluation committee	A body that serves in an advisory capacity to evaluate proposals in response to a request for proposal.
managed care	An approach to health care cost containment that enables the State to prospectively influence the delivery of health services.

Medicaid	Michigan's Medical Assistance Program operated under the authority of Title XIX of the Social Security Act.
outstate Michigan	The 78 counties other than the 5 counties in Southeast Michigan (Wayne, Oakland, Macomb, Washtenaw, and Genesee).
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
readiness review	A review by DCH and independent contractors to assess the degree of preparedness of qualified health plans prior to contract finalization.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
RFP	request for proposal.
value purchaser	An entity that purchases specified services and ensures accountability for quality outcomes while operating within a fixed budget.